



Medicare 101: What is Medicare and How Does it Work?

Medicare was created in 1965 as part of President Lyndon Johnson's Great Society program. The vision behind Medicare was to establish a safety net for America's seniors to help defray the significant cost of medical care. But today the Medicare safety net is fraying as the focus of health care shifts away from acute care to preventative medicine.

For nearly four decades, Medicare has served as a health insurance program for seniors and the disabled. Created in 1965, Medicare was designed as a "safety net" for our country's oldest, poorest, and most vulnerable citizens. Today, over 40 million Americans, 75% of which have incomes below \$25,000, depend on Medicare to provide them with the care they need to stay healthy. Although we often think of the Medicare population as a homogeneous group, there is actually significant diversity amongst beneficiaries. For example, in addition to seniors and the elderly, Medicare also covers over 5 million Americans under the age of 65 with permanent disabilities.

There are two primary components to Medicare today – Part A, financed through a 2.9% payroll tax, covers inpatient hospital care. Part B, funded through monthly premiums (generally \$66.60 in 2004) drawn from the Social Security checks of Medicare beneficiaries, covers doctors' visits and a limited number of outpatient services. A third component, Medicare Advantage (sometimes referred to as Part C), allows a number of additional private health plans such as preferred provider organizations (PPOs) and health maintenance organizations (HMOs) to administer Medicare benefits.

Policy makers face several challenges in attempting to strengthen and improve Medicare. Currently, Medicare does not provide coverage for many preventive measures, dental care, long-term care, or vision care. The program will continue to face financial pressures as the number of beneficiaries balloons from 39 million today to nearly 80 million by 2030. The retirement of the baby boomers means that there will be fewer workers contributing to the Hospital Insurance Trust Fund. Finally, there are administrative problems that must be dealt with if Medicare is to provide beneficiaries with the quality care they deserve. Meaningful reform must address all of these issues to ensure that the "safety net" that was created over three decades doesn't fray to the point where seniors and patients in need fall through the cracks.

While there are undoubtedly changes that can be made to further modernize Medicare and to ensure its continued value to beneficiaries, we should not

overlook the significance of the program. Given the fact that over 75% of beneficiaries have incomes below \$25,000 per year, Medicare provides millions of seniors and patients with medical insurance that they would not otherwise be able to afford. Medicare is also responsible for significantly increasing the quality of life for its beneficiaries by covering medical procedures such as hip replacement, heart bypass surgery, and diabetes monitoring. More recently, the program has also covered the costs of hospice care, a combination of mental counseling and pain relief for the terminally ill. Medicare also plays an important, albeit unconventional role, in financing a number of vital medical institutions. These include rural hospitals, hospitals that treat large numbers of low-income patients, and teaching hospitals that incur additional costs training tomorrow's doctors and developing new technologies. Without the payments that Medicare provides, the very existence of these institutions would be tenuous at best.

Understanding how Medicare is financed and why a problem exists

Although many have called for efforts to ensure the "solvency" of Medicare, little explanation has been provided to help Americans understand why the system is in trouble. Put quite simply, Medicare's costs are expected to grow more quickly than the economy is over the next few decades. Cost increases are driven by two factors: an increase in the costs per beneficiary, owing to advances in medical science, and an increase in the overall number of individuals covered by Medicare. Experts estimate, in fact, that by the year 2030, nearly one in four Americans will be Medicare beneficiaries. Technically, only the Hospital Insurance (HI) Trust Fund – which reimburses hospitals for inpatient care – can become insolvent. This is because the HI Trust Fund, better known as Medicare Part A, is almost entirely funded by a payroll tax of 2.9%. Thus, the revenues that the government collects for Part A will decline significantly as the baby boomers begin to retire and no longer pay into the system through the payroll tax. After retirement, these same individuals will also become Medicare beneficiaries, thereby increasing the amount of money that must be withdrawn from the HI Trust Fund to ensure they receive medical care. At some point, when expenditures from the fund exceed its revenues, the well will run dry and Part A will become insolvent.

Part B of Medicare – which covers doctors visits and other outpatient medical services – is funded by the Supplemental Medical Insurance (SMI) Trust Fund. This fund can never become insolvent because 75% of its revenues come from general taxation while 25% of its revenues come directly out of beneficiaries' social security checks.

Are the estimates accurate?

The Medicare program Board of Trustees, established by the Social Security Act to oversee the financial operations of the Parts A and B trust funds, reports annually on Medicare's fiscal status. The 2003 Trustees report, released in March, projected that combined Part A and B expenditures would increase from 2.6 percent of U.S. Gross Domestic Product (GDP) in 2002 to 5.3 percent in 2035 and then to 9.3 percent in 2077. Examined individually, Part A (HI) Trust

Fund expenditures are projected to exceed income by 2012 with the Trust Fund reserves being completely depleted by 2026. The Part B Trust Fund, because it is funded by beneficiary premiums, is projected to maintain adequate financing for the indefinite future.

Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA 2003), Medicare's Board of Trustees must annually review Medicare program spending as a percentage of general Medicare fund revenues. If Medicare spending is projected to exceed 45% of general revenues, MMA 2003 requires the President to submit legislation to change Medicare to lower spending below 45% of general revenues. MMA 2003 also creates an expedited legislative procedure for House and Senate consideration of this legislation.

This new fiscal safeguard will help put the program on stronger financial footing by alerting Congress and the President when Medicare's dedicated reviews fall below adequate levels.

Tomorrow's Beneficiaries Pay for Today's Benefits

Because Part A of Medicare derives most of its revenues from the payroll tax and it is a pay-as-you-go program, it places a disproportionate financial burden on younger Americans. Every dollar coming into the system is immediately spent on Medicare benefits for seniors and patients, leaving no guarantee that today's workers will have inpatient benefits under the program when they retire.